

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04942

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH:

County... Cecil

City or town... Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Cecil

City or town... Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Harry Arkatun

3. (b) Social Security Number

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife Mary Arkatun

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan 28 1889

8. AGE:

Years 58

Months 5

Days 5

If less than one day

..... hrs. min.

9. Birthplace

Austria

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Peter Arkatun

13. Birthplace

Austria

MOTHER

14. Maiden name

Pascha Dukhovskiy

15. Birthplace

Austria

16. Informant

Mary Arkatun

Address

Chesapeake City, Md

17.

(Burial, cremation, or removal, Which?)

Date thereof Jan 26 1947

(month) (day) (year)

Cemetery or crematory

St Marys Cemetery

Location

Phila Pa

18. Funeral director

H W Pissin

Address

Exeter Md

19.

(Date rec'd by registrar)

19 47

Mrs Pissin

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 47, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

DURATION

Acute coronary

Due to

Thrombosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

R. L. Dockson M.D. Examiner

23. SIGNATURE

Priscilla Sumner M. D. or other

Address

Date signed 6/24-47

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

JUN 27 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

04943

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County.....Cecil
 City or town.....Elkton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 19 days
 Hospital, institution, or street address where death occurred:
Union Hospital
 How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Cecil
 City or town.....Childs
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Florence Ann Blake

3. (b) Social Security Number

4. Sex.....Female
 5. Color or race.....White
 6.(a) Single, married, widowed, or divorced.....Married
 6.(b) Name of husband or wife.....J. Frank Blake, Sr.
Childs, Md.
 6.(c) If alive, give age.....84 years
 7. Birth date of deceased (mo., day, yr.).....September 7, 1866
 8. AGE: Years.....80 Months.....9 Days.....11 If less than one day..... hrs. min.

9. Birthplace.....Carroll County, Md.
 (Town, county, and state)

10. Usual occupation.....Housewife

11. Industry or business.....

12. Name.....John Burke

13. Birthplace.....Cecil County, Md.

14. Maiden name.....Annie Howard

15. Birthplace.....England

16. Informant.....Daughter Emily Cameron

Address.....Rising Sun, Md

17. Burial Date thereof June 21, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Leeds - Methodist

Location.....Leeds, Md.

18. Funeral director.....H. W. Phipps & Son H.C. Lutz

Address.....Elkton, Md.

19. June 19, 1947 Registrar.....J.H. Frager
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....June 18, 1947 19....., at 1.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 30, 1947 19..... to June 18, 1947 19.....
 and that I last saw h.....er..... alive on June 18, 1947 19.....

Immediate cause of death.....Carcinoma of small bowel with obstruction
 DURATION.....3 yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

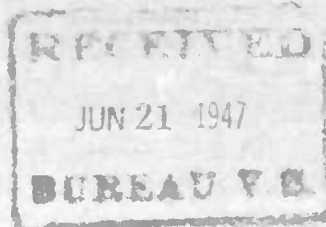
Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?.....

23. SIGNATURE.....J. H. McKnight M.D. M. D. or other

Address.....Elkton - Md. Date signed.....June 18-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04944

Reg. Dist. No. 96

1. PLACE OF DEATH:

County EastCity or town New Charleston

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 3 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarlCity or town New Charleston

(If outside city or town limits, write RURAL and give nearest town)

Street No. Carpenters Point

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Arthur Bertram Bonner

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Nellie Bonner7. Birth date of deceased (mo., day, yr.) Dec. 3 - 18766. (c) If alive, give age 61 years

8. AGE:

70 Years6 Months9 Days

If less than one day

..... hrs. min.

8. Birthplace London, England

(Town, county, and state)

10. Usual occupation Plumber

11. Industry or business

12. Name James Bonner13. Birthplace England14. Maiden name Unknown

15. Birthplace

16. Informant Mrs. Nellie Bonner (wife)Address Carpenters Point, Carl G. Md.17. Cremation Date thereof 6/16/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenwood CemeteryLocation Greenwood Ave. & Olive, Pk. Md.18. Funeral director Pennington & SonAddress Harve de Place, Md.19. June 16 19 47 June E. Daugherty

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 19 47 at 2⁰⁶ P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw him alive on June 12 19 47

Immediate cause of death

Accidental Drowning

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of June 12, 1947Where did injury occur? Carpenters Point, Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public PlaceMeans of injury Drowning in river Injured at work? No23. SIGNATURE Dr. Ford H. Sprecher, M.D.Address 3401 N. Charles St., Baltimore, Md. Date signed June 12, 1947

DECLARATION OF DEATH

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JUN 17 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 94

1. PLACE OF DEATH:

County... Cecil
 City or town... North East
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? M

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... Cecil
 City or town... North East
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

SUZANNA DeMonde

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife 7. Birth date of deceased (mo., day, yr.) 8. AGE: Years Months Days if less than one day

Joseph Hecker DeMonde
 Aug 11 1871
 75 10 — hrs. min.

9. Birthplace North East Rural, Cecil Co, Md
(Town, county, and state)

10. Usual occupation None

11. Industry or business Leslie Md

12. Name J. Wesley Hamilton

13. Birthplace Leslie Md

14. Maiden name Ann Marie Mullen

15. Birthplace Leslie Md

16. Informant Mrs Letta Cameron

Address North East Md

17. Burial, cremation, or removal. Which? Date thereof June 12-1947
(month) (day) (year)

Cemetery or crematory Methodist

Location North East Md

18. Funeral director Joseph P. Evans

Address North East Md

19. 6-15-1947 Lida E. Clevins
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1947 at 1058 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 1947 to June 11 1947
 and that I last saw him alive on June 9 1947

Immediate cause of death Uremic poisoning

DURATION

3 days

Due to chronic interstitial nephritis 3 days

Due to

Other conditions Gastritis and gall bladder

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE James L. Johnson M.D.

M. D. or other

Address 212 E. High St., Ellettsville, Ind. Date signed 6/14/47

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1. NAME OF DECEASED

DATE OF DEATH

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF NEXT OF KIN

14. SIGNATURE OF CLERK

15. SIGNATURE OF JURY

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF DISTRICT ATTORNEY

20. SIGNATURE OF COUNTY CLERK

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JUN 18 1947

BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

468

04946

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH:

County Cecil Co.
City or town Rising Sun, rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Cecil Co. Md.
City or town Rising Sun, Rural Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Arthur Ellen

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Ray Ellen
6. (c) If alive, give age 42 years
7. Birth date of deceased (mo., day, yr.) Nov. 15, 1873

8. AGE: Years 74 Months 7 Days 13 If less than one day hrs. min.

9. Birthplace Oak Co. North Carolina
(Town, county, and state)
10. Usual occupation Laborer on Farm

11. Industry or business

12. Name Calvin Ellen
13. Birthplace N.C.
14. Maiden name unknown
15. Birthplace N.C.

16. Informant Harley Ellen
Address Rising Sun, Md. R. F.D.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof July 1, 1947
(month) (day) (year)

Cemetery or crematory Baptist Cem
Location Conowingo Md.
J. E. Tyson

18. Funeral director J. E. Tyson
Address Rising Sun Md.

19. Date recorded by registrar June 30, 47 Registrar Ed Washington
Record 6-26-47

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25, 47, 4 P.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26, 47 to June 25, 47
and that I last saw him live on June 26, 47

Immediate cause of death Carcinoma of stomach
Due to
Due to
Other conditions
(Include pregnancy within 8 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

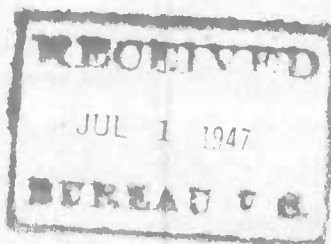
23. SIGNATURE W. D. Dooley M.D.
Address Rising Sun Md. Date signed 6/28/47

MARGIN RESERVED FOR BINDING

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VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1316

04947

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH: Cecil
 County.....
 City or town Elk Mills
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Cecil
 City or town Elk Mills
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME James Roy Forrester

3. (b) Social Security Number
 115-10-5627

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Mary Forrester
 7. Birth date of deceased (mo., day, yr.) Oct 1 1879 6. (c) If alive, give age 60 years
 8. AGE: Years 67 Months 8 Days 12 If less than one day
 hrs. min.

9. Birthplace Mountain City Tenn
 (Town, county, and state)

10. Usual occupation Labor

11. Industry or business Massey Paper mill

12. Name Calvin Forrester

13. Birthplace North Carolina

14. Maiden name no information

15. Birthplace Mountain City Tenn

16. Informant Mary Forrester

Address Elk Mills Md

17. Burial Date thereof June 16 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Elkton Cemetery

Location Elkton Md

18. Funeral director H W Pissin

Address Elkton Md

19. June 16 1947 19. 47 78 Frager
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1947 at 7:05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1947 to June 13 1947 and that I last saw him alive on June 12 1947

Immediate cause of death Chronic Insufficiency

Due to

Due to

Other conditions Chl. pneumonia

(Include pregnancy within 8 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James L Johnson M.D.

Address Elkton Md Date signed 6/16/47

M. D. or other

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C. 20530

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04948

Reg. Dist. No. 90

1. PLACE OF DEATH:

County Levitt
 City or town Earnville Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death 1st Friday
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Del. County Levitt Castle
 City or town Wilmington Del.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2921 Patnall
 (If rural, give LOCATION)
 2(a) If veteran, name war World War II

3. (a) FULL NAME

Robert Lewis Graham

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, year) Jan 19, 1922 8. (c) If alive, give age _____ years

8. AGE: Years 25 Months 6 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Wilmington Del.
 (Town, county, and state)

10. Usual occupation City Fireman

11. Industry or business

12. Name Robert Graham13. Birthplace Wilmington Del.14. Maiden name Virginia Graham15. Birthplace Wilmington Del.16. Informant Bernard A. LinnAddress 2921 Patnall St. Mil Del.17. Burial Date thereof 7-7-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cathedral BurialLocation Wilmington Delaware18. Funeral director 6 Goddard & SonAddress Mullington Md19. July 7 19 47 Mr. Howard W. Cheyney

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29, 1947, at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death Drowned

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of 6/29-47Where did injury occur: Wilmington Del. (City or town) (County) (State)Injured at home, farm, industry, public place (If other) Bathing BeachMeans of injury Swimming Injured at work? _____

Medical Examiner

23. SIGNATURE Dr. Donaldson Cecil CountyAddress Wilmington Date signed 7-2-47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04949

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil
 City or town Elkton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 days
 Hospital, institution, or street address where death occurred:
Union Hospital
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Cecil
 City or town Rising Sun Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Grace Eva Hale Harrington

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Arnold Bradford Harrington
 6.(c) If alive, give age 51 years
 7. Birth date of deceased (mo., day, yr.) Aug. 31, 1894
 8. AGE: Years 52 Months 9 Days 24 It less than one day _____ hrs. _____ min.

9. Birthplace Comers Rock, Va.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Fletcher Hale
 13. Birthplace Comers Rock Va.

14. Maiden name Sarah Wynn
 15. Birthplace Comers. Rock. Va.

16. Informant Hilma Harrington
 Address Rising Sun. Md. R. F. D.

17. Burial Date thereof June 28 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Halewell
 Location New Port Deposit. Md.

18. Funeral director J. E. Tyson
 Address Rising Sun. Md.

19. June 26 1947 Registrar J. E. Tyson
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 June 1947 at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946 to 25 June 1947
 and that I last saw h. er alive on 25 June 1947

Immediate cause of death Kremia DURATION 4 weeks

Due to Malignant Nephrosclerosis

Due to _____

Other conditions Diabetes Mellitus

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Klaus H Huebner M.D. M. D. or other _____

Address North East, Md Date signed 26 June 47

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JUN 27 1947
BUREAU V.A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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04950

Reg. Dist. No. 90

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Sevier
City or town Rowlandville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Sevier
City or town Rowlandville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Louis
Hugh Anthony Harry

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced 8 -

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 27 - 1947 6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
3 hrs. min.

9. Birthplace Rowlandville, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Hugh J. Harry
13. Birthplace Rock Springs

14. Maiden name Josephine German
15. Birthplace Baltimore, Md

16. Informant Hugh J. Harry
Address Rowlandville, Md

17. Burial (Burial, cremation, or removal, Which) Burial Date thereof July 2, 1947
(month) (day) (year)

Cemetery or crematory Little Britain, Pa.
Location Chester Co., Penna

18. Funeral director H. D. Bailey
Address Arlington, Md.

19. Date recorded by registrar June 30 - 47 Registrar L. M. Washington
Date recorded by registrar 6-30-47

MEDICAL CERTIFICATION

2D. DATE OF DEATH June 30 1947 at 3:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 1947 to June 29 1947 and that I last saw him alive on June 29 1947

Immediate cause of death Congenital Syphilis
Due to Blue Baby

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B. W. Harrison, M.D.
Address Ant. SE post Date signed 7/1/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED

JUL 3 1947

BUREAU V &

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1312

04951

95

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County CecilCity or town Rising Sun Rural.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County CecilCity or town Rising Sun Md. Rural.
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Brown Janney Jr.

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4, 19318. AGE: Years Months Days If less than one day
15 6 11 hrs. min.9. Birthplace Rising Sun Md.
(Town, county, and state)10. Usual occupation School boy.

11. Industry or business

12. Name Brown Janney.13. Birthplace Va.14. Maiden name Rosie Underwood15. Birthplace Va.16. Informant Mrs. Rosie HarringtonAddress Rising Sun Md. R. F. D.17. Burial Date thereof June 18, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Brookhaven CemLocation Rising Sun Md.18. Funeral director J. E. TysonAddress Rising Sun Md.19. June 17, 1947 2211 N. Charles St.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1947, at 3 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. H. Dolson Medical ExaminerAddress Rising Sun Md. Date signed 6/16/47

M. D. or other

100 Cecil County

6-17-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... Cecil
 City or town..... Perry Point
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 2 years
 Hospital, institution, or street address where death occurred:
 VAH, Perry Point, Md.
 How long in hospital or institution?..... VAH, Oteen, N.C. 7-13-37 to 4-8-43

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Baltimore
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2813 W. Lanvale Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... World War I ✓

3. (a) FULL NAME

Oscar W. Johnson

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Single
 6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... April 10, 1888
 8. AGE: Years..... 59 Months..... 2 Days..... 8 If less than one day..... hrs. min.
 9. Birthplace..... Sweden
 (Town, county, and state)
 10. Usual occupation..... Cook
 11. Industry or business.....
 12. Name..... Unknown
 13. Birthplace..... Unknown
 14. Maiden name..... Unknown
 15. Birthplace..... Unknown

16. Informant..... Hospital Records
 Address..... VAH, Perry Point, Md.
 17. Removal..... Date thereof..... 6/20/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Baltimore National Cemetery
 Location..... Baltimore, Maryland
 18. Funeral director.....
 Address..... Havre de Grace, Maryland

19. June 21, 19 47 Irene E. Daugherty
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 18, 19 47 at 11:20 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18, 19 45, to June 18, 19 47, and that I last saw him alive on June 18, 19 47.
 Immediate cause of death.....
 Tuberculosis pulmonary, chronic, active, far advanced
 DURATION..... 5 years
 Due to.....
 Due to.....
 Other conditions..... Adenocarcinoma, left suprarenal Unkwn, gland with metastasis, liver, lungs and kidneys
 (Include pregnancy within 3 months of death)
 Major findings of operations.....
 Date of op.
 Autopsy results..... Same as above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur?
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE.....
 A. E. TROLLINGER, M.D., Clin. Director
 Address..... VAH, Perry Point, Md. Date signed..... 6-18-47

RECEIVED

JUN 24 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information factually. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 049932

1. PLACE OF DEATH:

County Cecil
 City or town Elkton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 years
 Hospital, institution, or street address where death occurred:
E. Main St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State And. Cecil County Cecil
 City or town Elkton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

James Everett Lewis

3. (b) Social Security Number

4. Sex M. 5. Color or race White 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Carrie Otwell Lewis
 7. Birth date of deceased (mo., day, yr.) Oct 7 1891 8. (c) If alive, give age 50 years
 8. AGE: Years 55 Months 7 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Virginia
 (Town, county, and state)
 10. Usual occupation Retired
 11. Industry or business _____
 12. Name James E Lewis
 13. Birthplace VA
 14. Maiden name Sarah Anna Churn
 15. Birthplace Virginia

16. Informant Everett Lewis
 Address Elkton Md.
 17. Burial Date thereof June 6, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Forest
 Location Middletown, Delaware
 18. Funeral director W. P. Pippin
 Address Elkton, Md.
 19. June 6 19 47
 (Date rec'd by registrar) Registrar F. F. Frazee

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 19 47, at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death _____ DURATION _____

Acute coronary thrombosis

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. P. Pippin Medical ExaminerAddress Elkton, Md. Sur. Cecil CountyDate signed 6-4-47 M. D. or other _____

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JUN 9 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County... Cecil
City or town... Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Hrs.
Hospital, institution, or street address where death occurred:
Union Hospital
How long in hospital or institution? 8 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Maryland County... Cecil
City or town... Charlestown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Ogoretta F. Lewis

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife James L. Lewis
6. (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) August 26, 1906
8. AGE: Years 40 Months 9 Days 13 If less than one day hrs. min.

9. Birthplace Harrisonburg, Rockingham Co., Va.
(Town, county, and state)
House Wife

10. Usual occupation

11. Industry or business

12. Name Samuel Mc Crary
13. Birthplace Va.
14. Maiden name Mary M. Life
15. Birthplace Va.

16. Informant James L. Lewis
Address Charlestown, Md.

17. Burial Date thereof June 10, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Charlestown
Location Charlestown, Cecil Co., Md.

18. Funeral director Lee A. Patterson & Son
Address Perryville, Md.

19. June 9 1947
(Date rec'd by registrar) Registrar FR Fraser

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 June 1947 at 8 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 June (M) 1947 to 6 June 1947
and that I last saw her alive on 7 June 1947

Immediate cause of death CARDIAC FAILURE DURATION

Due to MITRAL STENOSIS

Due to RHEUMATIC HEART DISEASE

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Sadgusky MD M. D. or other

Address Perryville, Md. Date signed 8 June 47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

RECEIVED
JUN 11 1947
OFFICE OF THE
ATTORNEY GENERAL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

942

04955

CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH:

County CecilCity or town Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 79 yearsHospital, institution, or street address where death occurred:
Chesapeake City

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County CecilCity or town Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

4. Sex M.5. Color or race Wh6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) April 14 1868

6.(c) If alive, give age _____ years

8. AGE: Years 79 Months 1 Days 13 If less than one day _____ hrs. _____ min.9. Birthplace Chesapeake City
(Town, county, and state)10. Usual occupation Rt. Farmer

11. Industry or business _____

12. Name Charles Morgan13. Birthplace Maryland14. Maiden name Rebecca Robinson15. Birthplace Maryland16. Informant Mrs. Selma MorganAddress Chesapeake City, Md17. Burial Date thereof June 4 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BethelLocation Near Chesapeake City, Md18. Funeral director H.W. PippinAddress Elkton, Md19. June 4 1947 Registrar Mrs. Pippin
(Date rec'd by registrar)

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1947 at 5:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 22 1947 to June 1 1947and that I last saw him alive on May 31 1947

Immediate cause of death _____

Coronary occlusionDue to Coronary Sclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Thos. J. Davis M.D.

M. D. or other

Address Chesapeake City, Md Date signed 6/4/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

JUN 5 1947

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04956

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
 City or town Perry Point
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr. 1 mos. 11 days
 Hospital, institution, or street address where death occurred:
VAH, Perry Point, Md.
 How long in hospital or institution? Since July 14, 1943

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Pennsylvania County _____
 City or town Rosemont
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rosemont College
 (If rural, give LOCATION)
Spanish American
 2. (a) If veteran, name war _____

3. (a) FULL NAME

O'DONNELL, Anna E.

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1861
 8. AGE: Years 86 Months 3 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace New York State
 (Town, county, and state)

10. Usual occupation Nurse

11. Industry or business _____

MOTHER FATHER
 12. Name Unknown
 13. Birthplace Unknown
 14. Maiden name Unknown
 15. Birthplace Unknown

16. Informant Hospital Records
 Address _____

17. Removal Date thereof June 9, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Unknown
 Location Saugerties, New York

18. Funeral director PENNINGTON & SON
 Address Havre de Grace, Maryland

19. June 9, 1947 J. E. Dougherty
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8, 1947 at 12:02 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27, 1945 to June 8, 1947
 and that I last saw him alive on June 8, 1947

Immediate cause of death _____ DURATION
Pneumonia, left lower lobe 21 days

Due to Hypertensive cardiovascular disease; Hypertension, generalized Unknown

Due to _____
 Other conditions Pneumococcal infection
Endocarditis
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results Same as above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE A. E. TROLLINGER M. D. or other
A. E. TROLLINGER, M.D., Clinical Director
 Address VAH, Perry Point, Md. Date signed 6-8-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 10 1947

BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04957 90

1. PLACE OF DEATH: Cecil
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Md..... County..... Kent
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME
Horace Thomas. Otwell

3. (b) Social Security Number
514-03-0630

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife: Fannie B. Otwell

7. Birth date of deceased (mo., day, yr.) June 3, 1907 6. (c) If alive, give age..... years

8. AGE: Years 40 Months Days It less than one day
..... hrs. min.

9. Birthplace Delaware (Town, county and state)

10. Usual occupation Painter

11. Industry or business

12. Name: Harley Otwell

13. Birthplace Delaware

14. Maiden name: Sadie King

15. Birthplace Delaware

16. Informant: Fannie B. Otwell

Address: Galena Md.

17. (Burial, cremation, or removal, Which?) Burial Date thereof June 13, 1947 (month) (day) (year)

Cemetery or crematory: Galena

Location: Galena Md.

18. Funeral director: E. J. Taylor

Address: Millington Md.

19. June 17, 1947 (Date rec'd by registrar) Registrar: Mrs. James W. Cheyney

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10, 1947, 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to 19..... and that I last saw him alive on June 10, 1947.

Immediate cause of death: Accidental Drowning
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: June 10, 1947
Accident, suicide, or homicide: Accident Date of.....
Where did injury occur? Fredericktown Cecil Maryland (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public Place
Means of injury: Fell from dock Injured at work?

23. SIGNATURE: Dr. Ford N. Wyrecher, M.D. 1st Lt. Coronel D. or other
Date signed: June 10, 1947

MARGIN RESERVED FOR BINDING

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VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 14 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

8. (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereon

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h

Immediate cause of death

DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy report

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

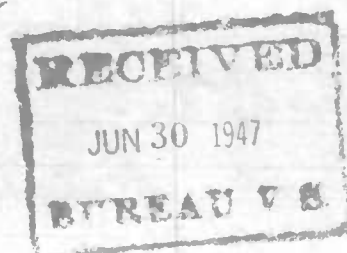
Address

Medical Examiner

Regd. County

M. D. or other

Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04959

1. PLACE OF DEATH:

County Cecil
City or town Port Deposit rural.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 years.
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md. County Cecil
City or town Port Deposit rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Adrianna Elizabeth Piere.

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Lott Piere
6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1895

8. AGE: Years 51 Months 5 Days 15 it less than one day _____ hrs. _____ min.

9. Birthplace Celora, Cecil Co. md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name William Philip Fulphel.

13. Birthplace Germany

14. Maiden name Catherine McClairgen

15. Birthplace Penna.

16. Informant Mr. Lott Piere

Address Port Deposit md.

17. Burial Date thereof June 5, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Brookview

Location Rising Sun, md.

18. Funeral director J. E. Tyson

Address Rising Sun, md.

19. June 4 - 47 6-4-47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-2 19 47 at 8:05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-1 19 47 to 6-2 19 47 and that I last saw her alive on 6-2 19 47

Immediate cause of death Pulmonary Embolism

Due to Coronary Thrombosis 11-2-46

Due to Chronic Myocarditis Scurvy

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Richard M. D.

Address Port Deposit md. Date signed 6-2-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 5 1947

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

04960

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH: County..... <u>Cecil</u> City or town..... <u>Elkton Rural</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... Hospital, institution, or street address where death occurred: How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Del.</u> County..... <u>Cecil</u> City or town..... <u>Elkton</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>Ethel Maud Reed</u>				3. (b) Social Security Number			
4. Sex <u>H</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Married</u>			
8. (b) Name of husband or wife <u>Jesse W Reed</u>				6. (c) If alive, give age <u>45</u> years			
7. Birth date of deceased (mo., day, yr.) <u>Jan 19, 1887</u>				8. AGE: Years <u>60</u> Months <u>5</u> Days <u>29</u> If less than one day hrs. min.			
9. Birthplace <u>Henderson, Ind.</u> (Town, county, and state)				10. Usual occupation <u>Housewife</u>			
11. Industry or business				12. Name <u>Thomas Bradley</u>			
13. Birthplace <u>Ireland</u>				14. Maiden name <u>no information</u>			
15. Birthplace <u>no information</u>				16. Informant <u>Robert Cahall</u> Address <u>Elkton RD 3 Ind.</u>			
17. Burial (Burial, cremation, or removal. Which?) Date thereof <u>June 20, 1947</u> (month) (day) (year) Cemetery or crematory <u>North East Cemetery</u> Location <u>North East 2nd</u> Funeral director <u>H W Phipps</u> Address <u>Elkton Ind</u>				20. DATE OF DEATH <u>June 17, 1947</u> at <u>9:15 P</u> M			
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19....., to 19..... and that I last saw him alive on 19..... Immediate cause of death..... <u>Acute Coronary</u> Due to <u>Arteriosclerosis</u> Due to..... Other conditions..... (Include pregnancy within 3 months of death)				DURATION			
Major findings of operations Date of op.				Antopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?				Medical Examiner Signature <u>Richardson</u> Address <u>Elkton Ind.</u> Date signed <u>6-17-47</u>			
19. June 19, 1947 <u>FR Frazee</u> (Date rec'd by registrar) Registrar				13. SIGNATURE <u>Richardson</u> Address <u>Elkton Ind.</u> Date signed <u>6-17-47</u>			

RECEIVED
JUN 21 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
 City or town Perry Point, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 yrs. 8 mos. 29 days
 Hospital, institution, or street address where death occurred:
VAH, Perry Point, Md.
 How long in hospital or institution? Unknown

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ohio County _____
 City or town No permanent home
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____ (If rural, give LOCATION)
 2(a) If veteran, name war WW-I

3. (a) FULL NAME

SMITH, Charles F.

3. (b) Social Security Number

None

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife --
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) March 5, 1879
 8. AGE: Years 68 Months 3 Days 19 If less than one day _____ hrs. _____ min.

9. Birthplace Ohio
 (Town, county, and state)
 10. Usual occupation Unknown
 11. Industry or business _____
 12. Name Robert Smith
 13. Birthplace Unknown
 14. Maiden name Unknown
 15. Birthplace Unknown

16. Informant Hospital records
 Address VAH, Perry Point, Md.
 17. Removal Date thereof June 27, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Baltimore National Cemetery
 Location Baltimore, Maryland
 18. Funeral director Pennington & Son
 Address Havre de Grace, Md.
 19. June 27, 1947 Irene E. Laughlin
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 1947 at 9:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 25, 1926 to June 24, 1947
 and that I last saw him alive on June 24, 1947

Immediate cause of death Hemorrhage, cerebral, subdural DURATION 2 hrs.

Due to Arteriosclerosis, generalized Unknown

Due to _____

Other conditions Coronary arteriosclerosis, severe Unknown
 (Include pregnancy within 3 months of death)

Major findings of operations --

Date of op. _____

Autopsy results Same as above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide -- Date of _____
 Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury -- Injured at work?

23. SIGNATURE A.E. TROLLINGER M.D., Clinical Director
VAH, Perry Point, Md. Date signed June 27, 1947

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 30 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04962

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil

City or town Elkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil

City or town Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Vandora Smith

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20 1879

8. AGE:

Years

Months

Days

If less than one day

67

7

26

hrs.

min.

9. Birthplace

Camden N.J.

(Town, county, and state)

10. Usual occupation

House work

11. Industry or business

FATHER

12. Name Matthew Smith

13. Birthplace Maryland

MOTHER

14. Maiden name Rachel Ann Gibbs

15. Birthplace Maryland (Snow Hill)

16. Informant Ida Carter

Address Chesapeake City Md

17. Burial Date thereof June 19 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bohemia Manor

Location Chesapeake City Md R.D.

18. Funeral director H W Bissin

Address Elkton Md

19. June 17 1947

(Date rec'd by registrar)

J R Trager

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1947 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1947 to June 15 1947

and that I last saw him alive on June 14 1947

Immediate cause of death

Myocardial infarction

Chronic heart disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature

Address Chesapeake City Md

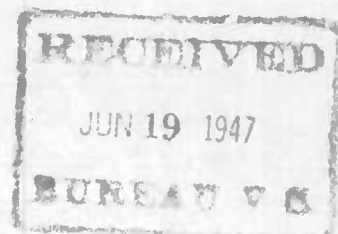
Date signed 6/17/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Evidence for the change of **MARYLAND STATE DEPARTMENT OF HEALTH**
years of birth is shown on 2411 N. Charles St., Baltimore 172

FILE No. G 11 JUN 27 1947 **CERTIFICATE OF DEATH**

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Perryville Rural
City or town Perryville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? per records
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Harford
City or town Churchville
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

George Walter Spicer, Jr.

3. (b) Social Security Number

4. Sex

M

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Josephine Eller Spicer

7. Birth date of

deceased (mo., day, yr.)

March 14, 1947 1916

6. (c) If alive, give age 28 years

8. AGE:

Years

31

Months

2

Days

28

If less than one day

hrs.

min.

9. Birthplace Wilkes Co. North Carolina
(Town, county, and state)

10. Usual occupation Civilian Gunner

11. Industry or business Aberdeen Proving Ground

12. Name George W. Spicer Sr

13. Birthplace Wilkes Co. North Carolina

14. Maiden name Annie Taylor

15. Birthplace Ash Co. North Carolina

18. Informant George W. Spicer Sr.

Address N. Wilkesborough, North Carolina

17. Burial Date thereof June 17, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Oak Grove Cemetery

Location Churchville, Harford Co. Md.

18. Funeral director Lee A. Patterson & Son

Address Perryville, Md.

19. June 17, 1947 Dr. E. Dougherty

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12, 1947 at 6:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to19.....

and that I last saw himalive on19.....

Immediate cause of death

Drowned

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6-12-47

Where did injury occur Lapitulum Harford, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) See Probation Room

Means of injury Pushed off boat Injured at work?

Medical Examiner R. E. Doelton

23. SIGNATURE Rising Sun Md. M. D. or other

Address Rising Sun Md. Date signed 6-16-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 19 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

04964

131a

1. PLACE OF DEATH:

County..... Cecil
 City or town..... Elkton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 days
 Hospital, institution or street address where death occurred: Elkton Union Hosp.
 How long in hospital or institution? 55 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Md. County..... Cecil
 City or town..... Rural near Elkton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.D. 1 Md.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3.(a) FULL NAME

William F. Stanley

3.(b) Social Security Number

4. Sex

M.

5. Color or race

Wh.

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Mary L. Stanley

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

May 25 1860

8. AGE:

Years

Months

Days

(If less than one day

87012

.....hrs.

.....min.

9. Birthplace

New Jersey
(Town, county, and state)

10. Usual occupation

Retired Farmer

11. Industry or business

FATHER

12. Name

Andrew Stanley

13. Birthplace

New Jersey

MOTHER

14. Maiden name

No Information

15. Birthplace

16. Informant

Blanch L. Aronson

Address

Elkton R.D. 1, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

June 9, 1947
(month) (day) (year)

Cemetery or crematory

Elkton

Location

Elkton, Md.

18. Funeral director

N.W. Rippin

Address

Elkton, Md.

19.

June 7 1947
(Date rec'd by registrar)F.R. Frager
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 6, 1947

19.....

1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 121947

to

June 6 1947

and that I last saw him alive on

June 5

19.....

1947

Immediate cause of death

Cardiac Failure

DURATION

Due to

Cardio-vascular-renal disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. Ford R. Spradley

M. D. or other

Address

Elkton, Md.

Date signed

June 6, 1947

RECEIVED

JUN 10 1947

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04965

Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... **Cecil**
 City or town..... **Perryville, Md. Rural**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... **50 Yrs.**
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Maryland** County..... **Cecil**
 City or town..... **Perryville, Rural**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

Annie Bernice Taylor

3. (b) Social Security Number

4. Sex..... **F** 5. Color or race..... **White** 6. (a) Single, married, widowed, or divorced..... **Married**
 8. (b) Name of husband or wife..... **Harry Taylor**
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... **Sept. 16, 1874**
 8. AGE: Years..... **72** Months..... **8** Days..... **23** If less than one day..... hrs. min.

9. Birthplace..... **Port Deposit, Md. Rural**
 (Town, county, and state)
 10. Usual occupation..... **House Wife**

11. Industry or business

FATHER 12. Name..... **John Jackson**
 13. Birthplace..... **Cecil Co., Md.**
 MOTHER 14. Maiden name..... **Rosalie Benjamin**
 15. Birthplace..... **Cecil Co., Md.**

16. Informant..... **Harry Taylor**
 Address..... **Perryville, Md. Rural.**

17. Burial..... **Burial** Date thereof..... **June 11, 1947**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... **Asbury**

Location..... **Port Deposit, Md. Rural**
 18. Funeral director..... **W. A. Patterson & Son.**
 Address..... **Perryville, Md.**

19. **June 11, 47** **June E. Daugherty**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **June 8, 1947** at **4:10 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Apr 10, 1946** to **June 7, 1947** and that I last saw him or her alive on **June 7, 1947**.

Immediate cause of death..... **Carcinoma of Stomach**
 DURATION..... **8 mos.**

Due to.....
 Due to.....

Other conditions..... **Chr. Myocarditis** **5 yrs**
Chr. Endocarditis **5 yrs**
 (Include pregnancy within 8 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE..... **B. J. Johnson M.D.**
 Address..... **Port Deposit, Md.** Date signed..... **6/9/47**

RECEIVED

JUN 14 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04966

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
 City or town Perry Point
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 yrs. 5 mos. 0 days
 Hospital, institution, or street address where death occurred:
VAH, Perry Point, Maryland
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State New Jersey County Essex
 City or town Irrington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 9 University Place
 (If rural, give LOCATION)
 2. (a) If veteran, name war WW-I

3. (a) FULL NAME

TEUSCHLER, Albert J.

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 8, 1890

8. AGE: Years 56 Months 11 Days 28 It less than one day hrs. min.

9. Birthplace Newark, New Jersey
 (Town, county, and state)

10. Usual occupation Unknown

11. Industry or business

12. Name Albert Teuschler - deceased13. Birthplace Unknown14. Maiden name Christina - deceased15. Birthplace Unknown16. Informant Hospital Records

Address

17. Removal Date thereof 6-9-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory UnknownLocation Irrington, New Jersey18. Funeral director Pennington & SonAddress Havre de Grace, Md.

19. June 9, 1947 June E. Daugherty
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1947, 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6, 1938, to June 6, 1947
 and that I last saw him June 6, 1947

Immediate cause of death Gangrene, both stumps (amputation, right leg 10-3-46; amputation, left leg 3-20-47) DURATION 1 Month
 Due to Arteriosclerosis, general; Arteriosclerosis, cerebral Over 10 yrs

Due to

Other conditions Left hemiplegia

Decubitus, sacral area
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury -- Injured at work?23. SIGNATURE A. E. Trollinger M. D. or other

A. E. TROLLINGER, M.D., Clinical Director

Address Perry Point, Md. Date signed 6-7-47

RECEIVED

JUN 10 1947

BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 04967

1. PLACE OF DEATH:

County... Cecil
 City or town... Chesapeake City, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 16 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Md County... Cecil
 City or town... Chesapeake City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No...
 (If rural, give LOCATION)
 2.(a) If veteran, name war... Not a Veteran

3. (a) FULL NAME

Thomas William Walton

3. (b) Social Security Number

169-20-1604

4. Sex... Male
 5. Color or race... white
 6.(a) Single, married, widowed, or divorced... married
 6.(b) Name of husband or wife... Sue R Walton
 6.(c) If alive, give age 39 years
 7. Birth date of deceased (mo., day, yr.)... Nov. 19- 1895
 8. AGE: Years 51 Months 6 Days 13 If less than one day hrs. min.

9. Birthplace... Buckingham, Virginia
 (Town, county, and state)
 10. Usual occupation... Senior Electrician
 11. Industry or business... U. S. Govt
 12. Name... Benjamin Walton
 13. Birthplace... Virginia
 14. Maiden name... Maybelle Long
 15. Birthplace... Virginia

16. Informant... Mrs Thomas W Walton
 Address... Chesapeake City, Md
 17. Burial, cremation, or removal, Which? Burial Date thereof... June 4, 47
 (month) (day) (year)
 Cemetery or crematory... Bethel
 Location... Chesapeake City, Md
 18. Funeral director... Joseph P. Hauer
 Address... North East, Md
 19. June 4th 19 47
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... June 1 19 47, at 7¹⁰ P M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 19 47, to June 1 19 47, and that I last saw him alive on June 1 19 47
 Immediate cause of death... Coronary thrombosis
 Due to... Coronary occlusion
 Due to...
 Other conditions...
 (Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE... [Signature] M. D. or other
 Address... Chesapeake City, Md Date signed... 6/1/47

Wed afternoon
2 P.M. DST

Frank R.H.

Frank R.H. call
from Eve,

1947
Credited 7
57

RECEIVED

JUN 5 1947

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 90

04968

93d

1. PLACE OF DEATH: Cecil
County Cecilton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Md County Cecil
City or town Cecilton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Martha J. Watts

3. (b) Social Security Number none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1854 8. (c) If alive, give age years

8. AGE: 92 Years Months Days If less than one day hrs.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name Henry Pierce

13. Birthplace Maryland

14. Maiden name Millimint Morgan

15. Birthplace Maryland

16. Informant Mrs. Julian P. Robinson

Address Cecilton Md.

17. Burial Date thereof June 4, 1947 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Cecilton

Location Cecilton Md.

18. Funeral director Edward Feltner

Address Millington Md.

19. June 4, 1947 Mr. Charles W. Cheyne (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 June 1947 at 1:10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 25 April 1947 to 2 June 1947 and that I last saw him alive on 1 June 1947

Immediate cause of death Myocardial failure DURATION 7 days

Due to Chronic Myocarditis 25 Apr 47

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Allan R. Cruehly M.D.

M.D. or other Address Mic Cecilton Md Date signed 2 June 47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

285-
50
205
360-
35

RECEIVED
JUN 5 1947
STREAN V B